Understanding the Role of Patient Advocate: Advocacy for our patients and advocacy for our professionals.

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Abstract

The initial focus is directly related to tort-law and the liability associated with making medical mistakes in a tort case. Our study originates on the idea that a patient advocate, with the patients' best interest in mind, would also serve the role as a risk management program, protecting and ensuring safety for patients and healthcare professionals alike. Through a basic professional opinion survey study, patient advocates will be asked a series of questions giving the researcher insight to the current role of patient advocates in healthcare settings.

Literature Review

Young consumers in western culture, in the United States specifically, according to a new Accenture survey, determined that Gen Z (born 1997 onward) healthcare consumers are not satisfied with the business and status quo of traditional healthcare. There is a clear trend showing a shift towards non-traditional healthcare services received by younger consumers. The Accenture 2019 Digital Health Consumer Survey was launched to investigate and study this trend. What they found was worth taking note. Healthcare marketing professionals are starting to see a shift in engagement in virtual care, retail walk-in clinics and other non-traditional healthcare practices. The Safavi & Kalis survey study (2019) suggests that around 55% of Gen Z and around 67% of Millennials are likely to have a primary care physician. That means Gen Z and Millennials are significantly less likely to utilize traditional healthcare techniques in comparison to other generations that do utilize primary care physicians such as Gen Xers (76%), Baby Boomers (84%) and the Silent Generation (85%). The study is quick to suggest the hypothesis that as Gen Z and Millennials continue to utilize non-traditional healthcare techniques, non-traditional styles of healthcare will continue to evolve and become more popular among all ages (Safavi & Kalis, 2019). The study proceeds to suggest that an estimated 29% of survey participants say they have utilized some form of virtual care which is a significant increase compared to an estimated 21% in 2017 (Safavi & Kalis, 2019).

As our healthcare system continues to evolve at such a rapid pace, patient satisfaction and patient-centered care will remain a constant. As we strive to exceed the limits of healthcare techniques and professional healthcare delivery styles, policies and standards will continue to shape our healthcare system. With new policies and standards continuing to mold this profession, advocacy for both patients and professionals will become a prominent role in

healthcare facilities (Blankenship & Duffy, 2015). An active internal patient advocacy program would facilitate the transition into non-traditional styles of healthcare, for the eHealth transition has begun globally (Black et al., 2011). According to the review, Black et al. (2011) eHealth technologies offer patients a variety of benefits including: storage, management, and transmission of health information; clinical decision making to receive more support from other professionals; and thirdly, the professional's ability to facilitate care from a distance. Documents, assessments, and health history, all can be shared with the approval of the patient which then allows the patient to receive professional opinions from a wide variety of healthcare professionals; thus, expanding the efficiency of the patient's progression towards treatment goals. As this study continues, the role of patient advocates and patient advocacy programs (or PAOs) will be investigated to strengthen the context of the desperate need for direct advocacy for, not only, patients but also healthcare delivery professionals (Blankenship & Duffy, 2015). This study will *research the role of a patient advocate or advocacy program as a risk management program in traditional health care facilities compared to non-traditional facilities in a rapidly evolving health care services and medical technology advancements in the Western culture: through a functional lens.*

Patient Advocacy. A patient advocate's role in the healthcare system can be highly misunderstood and not conceptualized to its entirety in healthcare facilities; thus, creating a significant gap between the concept of a patient advocate role or patient advocacy program and the reality of an active patient advocate role or patient advocacy program (Abbasinia, Ahmadi, & Kazemnejad, 2020).

Blankenship and Duffy (2015) identify three types of advocacy. The first general type of advocacy directly relates to specific patients or groups of patients who; for example, lack

insurance or the resources to obtain medical care such as elderly adults and children. The second type of advocacy also relates to advocacy for patients. The focus of this type of advocacy is to ensure that all patients receive high quality services; for example, patient-centered decision making, ensuring appropriate availability, and use of available resources. This style of advocacy is often defined as a professional's ethical responsibility given their professional understanding of current clinical and healthcare system issues (Blankenship & Duffy, 2015). The third type of advocacy is not for patients. In fact, Blankenship and Duffy (2015) suggest a unique style of advocacy; advocacy for professional societies. The authors suggest that the advocacy for individual professional societies indirectly promotes advocacy for patients and professionals who the professional society governs. Blankenship and Duffy (2015) proceed to argue that indirect advocacy; perhaps, needs to be more direct given the rapid transitions and challenges that healthcare providers face. Specifically, the rapid transition to telemedicine.

Mackey and Schoenfeld's (2016) scientific study suggest that as patients and families continue to gravitate to online healthcare campaigns, issues begin to appear stemming from mixed results of patient satisfaction surveys. Their article released on *BMC Medicine* shines light on a new form of "digital" patient advocacy concerned directly with issues pertaining to any patient confusion or frustration, ensuring reliable information about treatment options, and addressing current limitations with the structure of online healthcare delivery, ensuring all patients are satisfied with their healthcare service.

Koay & Sharp (2013) conducted a social research study focusing on the role of patient advocacy organizations emerging parallel to the exponential growth of medical research and development. Koay & Sharp (2013) characterize patient advocacy organizations (PAO) as the advocate's "*efforts… to give patients a greater voice and ensure that patients' interests are*

acknowledged by those in positions of power" (2013). They continue to provide evidence highlighting the advocacy for the practicing professionals by drawing attention to the PAO's collaboration with medical and healthcare professionals. Koay & Sharp argue that the relationship between the two professionals is important for the facilitation of the *"PAOs work in advancing the science not only by raising public awareness… and supporting research through philanthropic efforts, but also by participating in the design and conduct of [their] research"* (2013). The researchers proceed by pointing out the difficulty of singularly defining PAOs; however, they suggest that reviewing specific previous PAOs facilitates a greater understanding of a PAO's mission and structure (Koay & Sharp, 2013).

Susannah Rose, an Associate Professional Staff member in the Department of Bioethics at the Cleveland Clinic, released a research article to *The Journal of Law, Medicine & Ethics* revealing the efficiency of a highly understood patient advocacy program within a healthcare facility (Rose, 2013). Further dissection of the article reveals Rose's (2013) efforts to highlight the institutional barriers; such as interest, trust, and trustworthiness, faced by PAOs in their efforts to provide facilitation for transitions into new, patient-care protocols and caregiver-oriented education. These barriers often create a conflict between PAOs and the medical/healthcare professionals that interfere with the PAO's role that is discussed in the Koay & Sharp study. Barriers and professional conflicts between PAOs and licensed professionals disrupt the flow of the PAO's data collection, analysis, and disseminating the results (Koay & Sharp, 2013). The disruption in the flow of a PAO's role subjects respective parties to become uncertain in the legitimacy, authority, and organization of the researcher's protocol. Furthermore, the Koay and Sharp study (2013) identifies PAOs as a safeguard for patients ensuring boundaries, identities and representation of the patient's voice is present; likewise,

protect the practicing professionals from legal issues that stem from frequent patient-caregiver relationships such as informed consent and tort law.

Legal Issues. Lawsuits surround all health service professionals including; surgical doctors, medical doctors, general healthcare providers, and all other healthcare employees. Medical malpractice is a very serious issue for both healthcare providers and patients. In fact, errors that lead to medical malpractice occur during all stages of the healthcare process, such as the diagnostic stage, the treatment stage, and/or the post discharge treatment (Shipley, 2018).

The American Board of Professional Liability Attorneys (ABPLA) defines medical malpractice as "when a hospital, doctor or other health care professional, through a negligent act or omission, causes an injury to a patient" (ABPLA, 2020). Likewise, researcher Melinda Cooper (2011) calls attention to the modern experimental method of research, which she identifies, was established in the seventeenth century and was later refined by the term 'clinical trial' which became popular during the mid-twentieth century. Cooper's paper (2011) calls attention to the rapid advancements in clinical research to raise awareness of the increase in regulation of malpractice or accidents (tort law) that arise from practicing new forms of healthcare delivery.

Rebecca Dresser, the Daniel Noyes Kirby Professor of Law and Professor of Ethics in Medicine at Washington University in St. Louis, released a book in 2001 titled "When Science Offers Salvation: *Patient Advocacy and Research Ethics."* Dresser uses her platform to identify the immeasurable limits of the role of a patient advocate or advocacy program within a healthcare facility. She identifies specific roles such as the advocate's role in the rapidly changing research environment, the role in shaping and assessing science research, expanding access to experimental interventions, an advocate's role to be the voice of the public or

individual patient, and also discusses the recurrent themes faced by advocates in healthcare delivery settings. Dresser's discussion on the role of advocacy draws attention to the role of patient advocates or patient advocacy programs' service to provide risk management to protect practicing professionals from the legal side of their practice and also assist in supporting the healthcare professional's obligation to provide the highest level of care and recommendation services to their patients. Dresser (2001) suggests that a new breed of advocacy has gained popularity in healthcare administration settings. This new form of advocacy joins forces with scientists, doctors, clinicians, nurses and other healthcare professionals to represent patients and the public interest to retain the highest satisfactory and safest experience for patients to receive healthcare treatment. Dresser's identification of this new form and the new role of advocacy points in the direction of an advocate's inclusion in the administration body of healthcare facilities as a risk management program as scientific research continues to rapidly evolve and tort law continues to be an issue for practicing professionals.

Tort law is often used as an umbrella term to define all of the regularities in malpractice lawsuit cases. As healthcare professionals continue to conduct research and clinical trials, the term 'evidence-based practice' becomes more developed with each study; however, achieving those answers requires risks that lead to tort cases (Cooper, 2011). With each new study, a multitude of additional studies stem from one specific study; therefore, improving our understanding of the natural world around us. Mackey and Schoenfeld (2016) released an article studying this rapid transition. Their study specifically studies the transition into telemedicine and digital healthcare delivery techniques and identifies the variety of tort cases that inevitably result from this transition. With telemedicine and eHealth becoming more popular amongst younger generations, Mackey and Schoenfeld (2016) call for a new form of advocacy: '*digital*

advocacy' which directly combats the legal issues and tort law cases that a healthcare delivery professional may experience. Neglecting this rapid transition and failing to retain an updated knowledge of the legal policies and standards will result in many practicing professionals facing legal issues. Mackey and Schoenfeld's study's forecast on this call to this new form of digital advocacy indirectly shines light on the justification of a more developed role of a patient advocate in traditional care facilities. As we proceed, the different types of tort law will be discussed and the risk management that a patient advocate role can provide in a healthcare setting will be discussed. Tort law consists of three parts; intentional torts, negligence and strict liability/liability insurance. First, let's discuss intentional torts.

Intentional Torts. Intentional tort cases stem from medical professionals practicing their profession in a way that is outside of governing protocols and policies. Allen & Allen, define tort as a "*wrongful act resulting in injuries or damages*," the injured person "*may seek recovery from the person who caused the injury*" (Allen & Allen, 2018). In many cases the patient is accusing the facility or health professional of wrongful conduct; therefore, the accuser is considered the plaintiff in these cases. In healthcare litigation and standards of practice today, intentional torts do not necessarily constitute a crime or criminal action by the healthcare professional (2018). Allen and Allen (2018) identify intentional torts as a civil crime; however, in the courtroom, an intentional tort is much more liable to become a criminal offense compared to a negligent action.

Gerhard Wagner (2012) released an article to the Duke Journal of Comparative & International Law covering lessons learned from real world experiments that stem from tort and no-fault schemes. Wagner studies reveal that in modern healthcare, the tort system, specifically the intentional tort system has flaws and "*consumes a large fraction of the money… in the form*

of court and lawyers' fees instead of allocating the funds to victims for the purpose of compensation" (2012). Wagner suggests a new system identified as the 'No-fault scheme' which seeks to award tort victims a larger share of the costs included in the tort lawsuit; however, this scheme is flawed, for Wagner suggests that this new scheme serves as a deterrence and when the patient's health, body, and condition of either life and death are at stake, the effect of the larger sum of incentives is much smaller than anticipated, for more collateral does not repair or replace the damage that has been done. A recent study by Rubio et al. (2020) suggests that undergraduate education programs for healthcare students need to be taught more skills and legal issues; a specialty of a patient advocate role. Rather than focusing on providing the patients with compensation for ethical or legal wrongdoing, Rubio et al. (2020) analysis suggest that palliative care education is essential for healthcare workers to achieve their goal of "*reliev[ing] the suffering of patients and their relatives through an integrated treatment of the physical and psychosocial symptoms and to deal with their spiritual needs*" (Rubio et al., 2020). This analysis suggests that palliative care education improves the diversity of training and the diversity of the highest ethical and legal care provided to all patients; not only patients receiving palliative care. This form of diversity in training directly defines the role of a patient advocate in terms of the previously discussed study performed by Blankenship and Duffy (2015) that would not only advocate for the well-being of the patients and relatives, but also provide risk management protection for the practicing professionals. Secondly, this form of education as a risk management program provides an awareness and protection platform for more than just intentional torts, but also the second form of tort cases we will be discussing; negligence.

Negligence. The American Bar Association defines negligence as a person's "*liability stem[ing] from careless or thoughtless conduct or a failure to act when a reasonable person*

would have" (American Bar Association, 2016). Negligence becomes an issue when the legal duty was not met by the professional and there is a failure to comply with the standard or policy in place (2016). The American Board of Professional Liability Attorneys (ABPLA), the top medical malpractice attorneys in America, define medical malpractice in terms of negligent actions. Negligent actions can occur during many stages of the healthcare delivery process from "errors in diagnosis, treatment, aftercare or health management" (ABPLA, 2017). Negligent actions by healthcare professionals have the potential to cause a variety of risks; ranging from, a violation in the standards of care provided by governing bodies, injuries resulting from negligent actions, significant damages to the patient involved in the negligent; or perhaps, providing a healthcare service that is no longer accepted and recognized by national governing bodies: this is known as malpractice in most cases (2017). Specific examples provided by ABPLA (2017) include, "*failure to diagnose or misdiagnosis, misreading or ignoring laboratory results… improper medication or dosage, poor follow-up or aftercare, premature discharge, disregarding or not taking appropriate patient history, failure to order proper testing, failure to recognize symptoms,"* etc. In an attempt to limit acts of negligence, recent findings suggest that the role of patient advocate can help to supplement to improve patient's experience and safety in the healthcare delivery setting. A recent study by Katz et al (2012) suggests that a patient advocate assists in the treatment process by ensuring: patients have informed consent; promoting patient accrual with regards to procedures, eligibility, and cultural considerations; identifying the ethics of practice in the healthcare setting; and promoting patient and employee safety and confidentiality throughout the treatment process. The Katz et al (2012) online survey suggests that of those surveyed, only a minority of patient advocates reported having questions directed towards them in committee meetings; however, most of the participants reported that the

comments by patient advocates are considered and valued in treatment team meetings. Continuing on, let's discuss how patient advocates or PAOs can also serve to reduce liability in healthcare facilities and reduce the increase in liability insurance associated with intentional torts and negligence.

Tort Liability and Liability Insurance. As discussed in previous paragraphs, many lawsuits surround health service professionals including; surgical doctors, medical doctors, or general healthcare providers. In 2011, Daniel P. Kessler, a Professor of Law at Stanford School of Law released an article titled "*Evaluating the Medical Malpractice System and Options for Reform*." In his article, Kessler highlights the two principle objectives for our liability system; "*to compensate patients are injured through the negligence of healthcare providers and to deter providers from practicing negligently*" (2011). Kessler identifies multiple issues the modern liability system has including, "*fail[ing] to compensate who have suffered from bad [health] care and compensate[ing] those who haven't*" (2011). In turn, the lawsuits that surround healthcare and liability issues have inflated coverage prices for many parks & recreation facilities, sports facilities, and professional health-service providers as a whole. Most of these cases are directly correlated and made possible by the plaintiff by "tort law" and can occur with very large financial costs; especially considering the uninsured nonfinancial costs associated with these cases (2011). Researcher Joseph Thomas, who conducts research for Kasturba Medical College in Manipal, India, released an article in 2009 declaring an imperative that present-day medical doctors and healthcare providers must continue 'medico-legal' education (2009). With these ethical and legal interpretations changing at such a rapid pace, there is lots of room for an intentional tort or negligent action to occur within the system causing many legal issues to arise if the correct policies and guidelines for continuing education are not set in place

by a healthcare facility. Incorporating risk management and maintaining an effective doctor-patient relationship, a facility should invest in focusing on mandating a continuing education program, through a PAO or patient advocate, to assist professionals in maintaining awareness of the "*legal issues…include[ing] the basics of medical negligence, changing concepts of informed consent, and the practical issues of medical negligence cases*" (2009). The more a facility and its professionals retain awareness and receive education of the evolving standards and policies, the more prepared a facility can be to prevent or limit harmful experiences for employees and patients mutually. Often, there is a negative stigma around continuing education and recertification for many professionals; however, neglecting the constant change in practice and company guidelines will result in a decision "favor[ing] the patient who has suffered due to the negligent action of the doctor" (Thomas, 2009) or medical professional in any case filed against them for incorrect interpretations of ethical and legal governing standards and policies.

Introduction

Patient advocates and patient advocate programs play a vital role in healthcare today. Advocates of this form provide a voice for patients and provide patients with information that is not discussed with them or is explained in terms that may be over a patient's head. Many administration professionals associate the role a patient advocate or advocacy program exercises in a healthcare facility to doctors, nurses, or technicians in healthcare settings; however, it is apparent that professionals in these roles are focused on duties and job roles required by their main role in the treatment team. Furthermore, a patient advocate expands on these roles as a source to inform the service population within the community while the healthcare delivery professionals maintain focus on improving the care and quality of life of their patients.

Additionally, the role of a patient advocate or patient advocate program could provide protection to the practicing professionals within the facility by advocating for not only the safety of the patients but also advocating for the legal and ethical practice of the professionals. The patient advocate or advocacy program ensures the patients receive the highest level of care while maintaining legal and ethical standards and expectations that evolve as rapidly as the practice of healthcare delivery services. In western-culture healthcare delivery, often times doctors, nurses, and other professionals are focused on the well-being of all of their patients who are desperate for their level of professionalism. The role of the patient advocate is to ensure the safest experience for the patients receiving care. As we dig deeper into this study, we will begin to investigate the existing roles of a patient advocate or advocacy program within a healthcare facility. Our goal with this investigation is to survey patient advocates and receive their feedback and professional opinions on their specific role within their facility. Additionally, the intention of this study is to determine whether or not their advocacy role could be expanded on as a risk management program at an administrative level in their respective healthcare delivery setting; traditional and non-traditional.

Methods

Participants. Approved by the Oklahoma State IRB, participants will be selected based on a brief screening process involving a Linked-In profile screening search. The goal of the researcher is to identify approximately 30 'patient advocates' who work in a health-care related field. Participants must be adults working in the United States. The researcher intends to diversify the sampling population as much as possible including patients who are advocates for their own health as well as patient advocates who work under a non-profit or advocacy organization through a snowball sampling method.

It is understood that therapists in the healthcare setting are indirectly advocates for their patients; however, the overall goal of this study is to hone-in specifically on professionals who have the job title of 'patient advocate' to research the role of patient advocates in their administrative role. It is also the goal of the researchers to gain insight on whether or not professional 'patient advocates' believe their role is sufficient for their job title. By receiving their professional opinions through a survey study, the researcher seeks to better understand the specific role of a patient advocate and evidence that suggests a 'patient advocate' position should be expanded on in their respective healthcare facility. Through a variety of participants gathered by the snowball sampling method, a diverse understanding of roles of patient advocates will be analyzed, and a diverse data set will allow the researcher to analyze the unique ways patient advocates believe their role could be expanded on.

Survey. Similar to the Katz et al (2012) research study, a survey will be administered surveying and assessing the perceived role and the value that patient advocates have in their discipline. Using the snowball sampling method, the researcher intends to connect with professional patient advocates through Linked In and use participants professional network to identify other patient advocates working in healthcare. The researcher seeks to investigate the perspectives and professional opinions of patient advocates or representatives of patient advocacy programs in their respective facility. Using the survey platform 'Qualtrics,' a 38-item survey will be administered to participants identified as patient advocates. Other requirements are not required for survey participation; however, the researcher seeks to investigate the different administrative-influence levels patient advocates have within their administration team. Questions in the survey are originally created by the researcher and orient towards eliciting professional opinions of the pros and cons of the role of patient advocate in western healthcare systems today. The goal is to

understand these roles, and learn new techniques or ideas to qualitatively enhance the role of a patient advocate role as a risk management position. To increase the number of participants for this study, participants of the study will be asked to use their network of patient advocates to snowball the group of patient advocates participating in the study.

Data Analysis. Questions in the survey will be grouped in sections that answer a handful of questions. The grouping format will be utilized to analyze the professional opinion of a handful of questions all related to one specific role and/or participation in one part of the treatment process. First the study will ask participants if they are currently at a facility that employees a patient advocate or utilizes a patient advocacy program, followed by a group of questions to investigate co-existing roles that the patient advocate may have in the treatment team, such as a direct-care employee (a therapist, nurse, etc.) or an indirect care employee (administrator, intake, etc.). This set of questions will validate the specific job role that the participant was hired for; furthermore, validate questions of this investigation that may suggest that certain primary job roles are the primary focus for that job prior to their role as a patient advocate. The survey will continue with this format, asking questions in different groups to answer specific questions that will be addressed and analyzed in the results section. Using an exploratory data analysis method to analyze the survey results, the insights and opinions of professional patient advocates will be interpreted and patterns within the results will be discussed to understand the role of professional advocates in western healthcare today. Using our inferential statistical analysis method, the researcher also seeks to explore the visions and insights that participants have for developing a stronger, well-rounded patient advocacy program and atmosphere within their facility. The researchers intend to utilize the Chi Squared test to score the fit of the original hypothesis. To use this test with unbiased results, the test requires a minimum of 5 cell counts. If the minimal

thresh-hold of 5 participants is not met to use this test of best-fit; however, the researcher will utilize a case report style to analyze the responses of the participants and make inferences based on each individual participant's response.

Results

Case Report. After a two-week recruitment and data collection period, three professional patient advocates participated in the study. The goal of achieving 30 participants was not achieved; likewise, the minimum thresh-hold for the Chi Squared best fit was not achieved. The researcher, therefore, will utilize a case report style to make inferences based on the responses of each individual participant. Reluctantly, our participating patient advocates all embody entirely diverse roles as a patient advocate. Each participant's response will be analyzed to compare the differences and identify similarities in responses to survey questions.

Participant 1. The first participant was a patient advocate working in a non-traditional patient advocacy setting, specifically, the participant works for a pharmaceutical company. This style of advocacy is non-traditional because it is western-healthcare based; a non-traditional practice from a global standpoint. This participant's specific role engages directly in advocating for patient focused drug development (PFDD) and seeking outreach to receive patient feedback loops. It is not clear whether or not, but worth taking note, the patient advocate in this setting does not play a part in the discharge process. The participant did not distinguish a definitive response; therefore, this can only be noted as an inference. It is also worth noting that this participant does not believe that other administrative roles understand the role of the patient advocate. This raises a flag, because if administration doesn't understand the role of their patient advocate, it raises questions on how that administration could make internal changes based on the professional assessment of a position they do not understand. This participant also reports

that other administrative roles do not understand the patient advocacy program that the participant serves. In this pharmaceutical setting, the patient advocates seem to be less directly working with the patients, the patient advocate respondent for this survey reports that the patient advocate is not a direct care employee, such as a therapist, nurse, etc. This could be an interesting aspect to consider. With this patient advocate not having a co-existing role in the facility, it raises questions to whether this role can achieve more as an advocate, with no other job role commitments; whereas, a direct-care employee also must focus on those job duties. Alternatively, a direct-care employee who is also a patient advocate could offer advocacy more directly representative to the service population if they are directly caring for them and developing a more in-depth report with the patients they are advocating for. This avenue of time in comparison to our understanding of the role of patient advocate is definitely something worth researching more; however, not significantly investigated in this study.

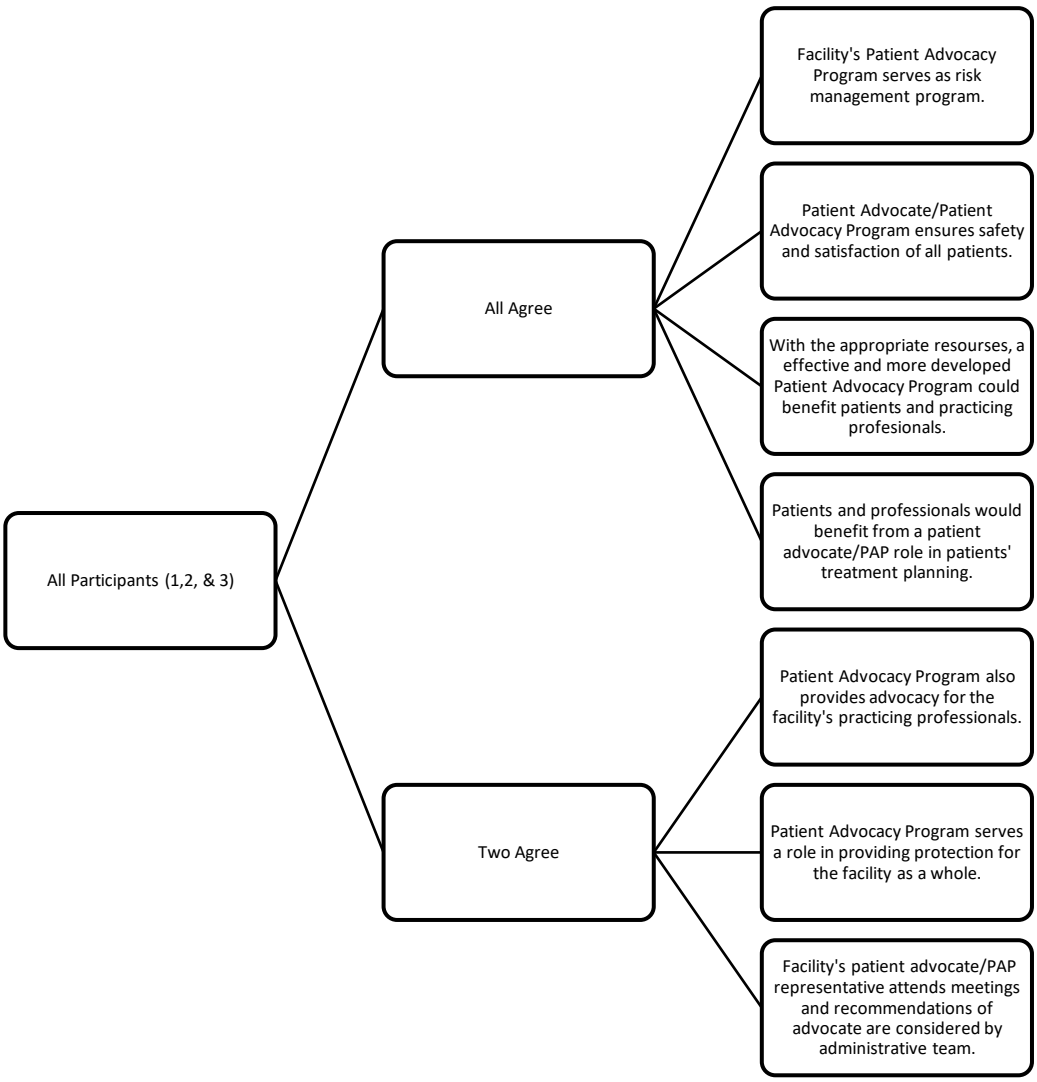
Participant 2. The second patient advocate participant in this study works in long-term care, assisted living and skilled nursing. This participant's free response to their professional opinion on how to achieve the most optimal programming for the patient advocacy program at their facility is interesting and worth investigating. At the beginning of the survey, the participant classifies as an indirect care employee; likewise, reports that in the role of patient advocate, isn't on the facility's cite most days of the week. This raises questions to the researcher of the ability of the patient advocacy program to function in this facility; however, the free response facilitates an inferenced answer to those questions. The participant believes that the "advocacy program should not be an 'in house' one." Furthermore, the participant believes that the advocacy program should be represented by a 3rd party and is resident and/or patient directed meaning that the advocates for the program itself are merely representative of the

patients themselves. This approach is very interesting and worth taking note of; however, the participant still notes that other administrative roles are not educated on the specific role of the patient advocacy program within the facility. This could be a result of the PAP being 'out-of-house' or 3rd party; however, again, this ties into the same questions drawn from Participant 1. Are these indirect-care employed advocates able to achieve more advocacy work for their clients working solely as an advocate or is this simply a difference caused by the service population these advocates are working for? Additionally, this draws new questions based on the responses of the participant. Are 'out-of-house' advocacy programs more efficient than 'in-house' programs? Are 'out-of-house' programs able to litigate policy within the organization by being 3rd party? Again, these are new questions drawn from the research performed in this study that should be investigated with further research.

Participant 3. The third participant in the professional opinion survey is a patient advocate who also works as a direct-care employee as a therapist in mental and behavioral health. Similar to the other participants, this participant reports that the facility might or might not benefit from a well-rounded patient advocacy program within their facility. Compared to the other participants, the patient advocate working also as a direct-care therapist, participates in the patient discharge process and actually administers the discharge satisfaction survey. This participant's response is intriguing because the patient advocate is receiving direct feedback about overall satisfaction of the patient's overall experience and satisfaction feedback on each discipline within the facility; doctors, nursing staff, technicians, etc. Additionally, in comparison to the other respondents, this participant specifically reported that the patient advocacy program in a mental and behavioral health facility has no problematic limits. Similarly, in comparison to the other responses, the third participant reports that the

administrative role of the patient advocate is understood by other administrative roles; likewise, the specific role of the patient advocacy program is well understood by the other administrators employed at the facility. It is important to note that participant three, who is also employed as a direct-care therapist, answered 'Agree' to more questions within the survey compared to the other participants. From the responses reported by participant number three, it can be inferred that based on our primary sample population, this patient advocate has the most administrative participation within their facility compared to other respondents. Counter-argumentatively, this survey participation draws on the same questions as the drawn by the responses of the other participants' responses. Participant three offers a counter argument because the patient advocate is a direct-care employee, and the patient advocate scored the highest and showed the most variety in specific job roles within the facility, including participating in treatment team planning and patient discharge planning. Are direct-care employees able to get a more direct and personal feedback from patients? Is an 'in-house' patient advocacy program more administratively efficient than an 'out-of-house' program? Similar to the former, these are questions that should be addressed and investigated through further research.

Similarities. The survey participants' responses had similarities that are positive notes and can be represented through graphic analysis. Questions within the survey start off with some basic screening questions to ensure the facility has a patient advocate or patient advocacy program. As the questionnaire continues, questions get more and more below the surface level of describing their job role; for example, the patient advocates respect by other administrators, participation in administrative meetings, participation in treatment planning, role as a risk management program, role to protect both patients and professionals, etc. Below you will find *Figure 1* describing some of the similarities within the participants' responses.



All Agree. Throughout the survey, there were many differences between the participants including the setting participants are employed in, their specific role within their facility and other questions that were answered differently; however, the similarities are relevant and applicable to the study. First all three participants agreed that the Patient Advocacy Program within their facility also serves as a risk management program. The similarities in answers to this question are important to note because the patient advocacy program should serve as a risk management program for patients and professionals. Although, not all patient advocates may play a role in their facility's risk management program, it is important to note the impact of

patient advocacy programs within different respective facilities. Likewise, the respondents all agreed that the patient advocacy program also elicits a safe and satisfactory experience for all patients receiving treatment. And furthermore, all participants agreed that with the appropriate resources, a better developed program could be implemented in the facility. This question is kind of unique and draws questions that should be further investigated. Is the patient advocacy program actually less developed from lack of budget funds or lack of perceived importance within the facility? Or is the program well developed and the representatives of the program believe it could be just that much better? The latter, suitably, a better question that should be investigated on new techniques and methods to achieve a higher functioning patient advocacy program. Finally, another important similarity within the results suggests that the participants of the study agree that the patient and multidisciplinary team would benefit from the patient advocate/PAP's participation in treatment team planning meetings. This is pretty clear and straightforward, the patient advocate should play a role in the treatment team meetings, for the sole role of the patient advocate is to advocate for their patients. With the numerous stages of the treatment process, the patient advocate should be able and willing to represent their patient in treatment planning meetings.

Two Agree. Moving down to the bottom half of *Figure 1*, the researcher found interesting results for some of the answers that only two of the participants agreed on. The differences within the setting of employment was not considered for this discussion; however, each question set with two 'agrees' will be subject to a counter-argument by the researcher.

The first notes from this analysis was that two out of the three respondents report that the patient advocate or advocacy program advocates for the protection of the practicing professionals and the facility they serve, as a whole. This is interesting because it brings light to the

participant that disagreed with these two questions and leads to further questions to be drawn by the researcher. Is the patient advocacy program being limited at an administrative level or corporate level? How would the patient advocate/PAP advocate for expansion of their role to advocate for protection of the facility and all members of the multidisciplinary team, including the patient? It would be interesting to analyze this result from a larger sample population to see the similarities from a much larger group.

Finally, the third blank in the 'two agree' category is actually interesting at the fact of not having all three agrees. Two respondents agreed that the patient advocate/PAP representative attends administrative team meetings and recommendations brought up by the patient advocate are taken serious and seriously considered. It is interesting to note that the other participant did not 'Agree' to this survey question, and again leads to a group of questions that should be considered. Why isn't the patient representative attending administrative meetings? If patients are first, who represents the patients in administrative meetings? Similar to the prior 'Two Agree' discussion, the counter-argument, or the participant that disagrees, draws more secondary questions that should be addressed with further research.

Discussion

Recommendations. First and foremost, the researcher recommends a larger sample population of patient advocates for future research investigations. The primary problem faced when recruiting participants was the study plan to utilize Linked-In to gather research participants. In order to collect participants from the Linked-In platform, the researcher was required to 'Connect' with other platform users and build up a personal network to connect with similar job roles in patient advocacy. A large amount of time during the data collection period was spent recruiting potential participants, who were primarily unlikely to connect with a Linked-In

member, like the researcher, with under 100 connections and no professional experience. With a larger time-frame for data collection, patient advocacy groups could be utilized to collect participants and achieve a survey pool of around 50-75 patient advocates. Furthermore, during the recruitment process, the researcher gained insights through seasoned researchers for additional avenues for future research; such as, Facebook groups, following Twitter hashtags to find advocates, joining advocate groups, finding groups of advocates who are also advocates for their own health, etc.

With the many risks associated with tort law, we must treat every patient, with respect to their own strengths and weaknesses, the most optimal treatment environment while eliciting a functional change. With that being said, it's important to be aware of these risks that may arise and have the risk management program that works best for the specific facility or specifically for the service population. Through this research, it is clear that the patient advocate or the facility's patient advocacy program would be an effective in this role of protecting our patients and our practicing professionals who providing health care services.

Future research should focus on identifying the enormous variety of patient advocates in our healthcare system. During the research process, the researcher found that patient advocacy isn't simply defined by 'traditional' and 'non-traditional' advocacy. Some advocates are advocates for their own health disability, some advocates work for pharmaceutical companies to ensure patient focused research, some advocates work in mental and behavioral health, some serve as direct-care employees, some advocates are in an administrative role, the list goes on and on. An exploratory analysis of the similarities and differences should be investigated with further research and a much larger sample population; likewise, the time aspect identified in the case reports should be further investigated. Are direct-care employees more patient-oriented

advocates? Are indirect-care advocates able to achieve more for their patients administratively? What role does a secondary job position within the facility play? These are new questions to be investigated to add to our knowledge of the role of patient advocacy and as an administrative team, make qualitative changes to ensure the highest level of patient advocacy within an organization with the well-being of the patient always first.

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